

EXHIBIT 143

MODEL LETTER TO PROVIDER (IMPOSITION OF REMEDIES) (IMMEDIATE JEOPARDY EXISTS)

NOTE: This letter would follow the SA's notice as required by §7309. The language provided below should be changed appropriately for surveys conducted by CMS.)

IMPORTANT NOTICE - PLEASE READ CAREFULLY

(Date)

Nursing Home Administrator Name
Facility Name
Address
City, State, ZIP Code

Dear **(Nursing Home Administrator)**:

On **(date)** a survey was conducted at your facility by the **(State survey agency)** to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with the participation requirements, and the conditions in your facility constituted immediate jeopardy to resident health or safety.

As a result of the survey findings, the **(State survey agency)** notified you **(date, method)** that it would recommend to the **(Centers for Medicare & Medicaid Services(CMS) Regional Office and/or the State Medicaid agency)** that **(temporary management or termination, and other remedies, if applicable)** be imposed.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (PoC)

A PoC for the deficiencies must be submitted by **(10 days after the facility receives its Form CMS-2567)**. Failure to submit an acceptable PoC by **(date indicated above as the due date for submission of a PoC)** may result in the imposition of **(list remedies)** by **(20 days after due date for submission of a PoC)**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;

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- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.

A change in the seriousness of the noncompliance to non-immediate jeopardy may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Allegation of Compliance

If you believe these deficiencies have been corrected, you may contact (name, title, address, and telephone and fax number of survey agency representative) with your written credible allegation of compliance.

Informal Dispute Resolution (IDR)

In accordance with §488.331, you have one opportunity to question cited deficiencies and to specifically contest scope and severity assessments for deficiencies which result in a finding of substandard quality of care (SQC) or immediate jeopardy through an IDR process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to **(name, title, address, and telephone number and fax number of the person who will be conducting the IDR process)**. This request must be sent during the same 10 calendar days you have for submitting a PoC for the cited deficiencies. An incomplete IDR process will not delay the effective date of any enforcement action.

ADD TO THE ABOVE PARAGRAPH IF THE SURVEY WAS CONDUCTED BY CMS:

IDR in no way is to be construed as a formal evidentiary hearing. It is an informal administrative process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for IDR so that we may also have counsel present. You will be advised verbally of our decision relative to the informal dispute, with written confirmation to follow.

(Name)

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Appeal Rights

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in §498.40, et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to:

Centers for Medicare & Medicaid Services
Associate Regional Administrator
Division of Health Standards and Quality
(Street Address)

At your option, you may instead submit a hearing request directly (accompanied by a copy of this letter) to:

Departmental Appeals Board
Civil Remedies Division
Attention: Gerald P. Choppin
Room 637-D
HHH Building
200 Independence Avenue, S.W.
Washington, D.C. 20201

Send a copy of your request to this office.

A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented by counsel at a hearing at your own expense.

USE THESE 3 PARAGRAPHS IF IMPOSING TEMPORARY MANAGEMENT:

We concur with the (State survey agency)'s recommendation. As a result, a temporary manager will be installed in your facility on **(date that is no sooner than 2 days after receipt of the notice and no later than 10 days after the survey date)**. You are expected to relinquish to the temporary manager the authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and otherwise manage the facility to correct the deficiencies identified in its operation. You will be responsible for paying the salary and related costs of the temporary manager, which will be set by the (State survey agency).

(Name)

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If you refuse to relinquish authority to the temporary manager or to pay his/her salary, your facility will be terminated on **(date that does not exceed 23 calendar days from the survey date)**, if the immediate jeopardy is not removed prior to this date.

If you relinquish authority to the temporary manager, the temporary management will end when your facility has achieved substantial compliance and is capable of remaining in substantial compliance, or when your facility's provider agreement is terminated. Termination will occur on **(date that is 23 calendar days from the last day of the survey)** if the immediate jeopardy is not removed.

USE THESE 2 PARAGRAPHS IF IMPOSING TERMINATION:

We concur with the **(State survey agency)**'s recommendation. Your **(Medicare or Medicaid)** provider agreement will be terminated on **(date that is no sooner than 2 days after receipt of the notice and no later than 23 days after the survey date)** if the immediate jeopardy to resident health or safety is not removed. **(NOTE: If Medicaid, add: We will notify the State Medicaid Agency to terminate your Medicaid provider agreement.)**

We are required to provide the general public with notice of an impending termination and will publish a notice in **(paper's name)** prior to the effective date of termination.

USE THIS PARAGRAPH IF IMPOSING A CIVIL MONEY PENALTY (CMP)

In addition to **(temporary management or termination)**, a CMP has been imposed in the amount of **(amount)** per day commencing on **(the date that the facility was first found out of compliance)**. The CMP will continue to accrue until the deficiencies are corrected and your facility is found to be in substantial compliance, or your provider agreement is terminated. The CMP will not be collected until after it has stopped accruing and a final administrative decision upholding its imposition has been made, if a hearing is requested. If you waive your right to a hearing within 60 calendar days from **(the date the CMP stops accruing)**, the amount of your CMP will be reduced by 35%.

USE THIS PARAGRAPH IF SUBSTANDARD QUALITY OF CARE IS IDENTIFIED:

Your facility's noncompliance with the following **(cite regulations)** has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act, as well as implementing regulations at §488.325(h), require that the attending physician of each resident who was found to have

received substandard quality of care as well as the State Board responsible for licensing the

(Name)

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facility's administrator, be notified of the substandard quality of care. In order for us to satisfy these notification requirements, and in accordance with §488.325(g), you are required to provide the following information to this agency within 10 working days of your receipt of this letter:

The name and address of the attending physician of each resident found to have received substandard quality of care, as identified below:

List of affected residents:

Please note that, in accordance with §488.325(g), your failure to provide this information timely will result in termination of participation or imposition of alternative remedies.

USE THIS PARAGRAPH IF SUBSTANDARD QUALITY OF CARE HAS BEEN IDENTIFIED ON 3 CONSECUTIVE STANDARD SURVEYS:

The finding(s) of substandard quality of care found during this survey constitute(s) 3 repeated findings of substandard quality of care, i.e., findings of substandard quality of care on the last 3 consecutive standard surveys of this facility. As a result, regardless of other remedies, **(CMS and/or the State Medicaid Agency)** must deny payment for all new admissions, effective on **(last day of survey + 20 days)** and impose State monitoring, effective **(last day of survey + 5 days)**.

If you have any questions, please contact **(name, title, address, phone number and fax number of appropriate survey agency official)**.

Sincerely yours,

(Name and Title)

cc: CMS Regional Office

and/or State Medicaid Agency